



Eastern Shoshone Child Support Program

PO Box 1573

Fort Washakie, WY 82514

Office Phone Number: 307-335-8371

Fax Number: 307-332-3089

CONFIDENTIAL INFORMATION RELEASE AND AUTHORIZATION

[A COPY OF THIS DOCUMENT IS AS VALID AS AN ORIGINAL]

Individual Who is Subject of Record:

<<CP // NCP Name>>	<<CP//NCP SSN>>	<<CP//NCP Date of Birth>>	
Name	Social Security Number	Date of Birth	
<<CP // NCP Mailing // Residence Address>>			
Address: Street	City	State	Zip Code

Person/Agency/Organization Being Authorized to Release Information:

<< [Insert] Authorized Party Name>>	<< [Insert] Authorized Party Org Name>>		
Name of party authorized to release information	Name of Organization		
<< [Insert] Authorized Party Address>>	<< [Insert] City>>	<< [Insert] State>>	<< [Insert] Zip Code>>
Address: Street	City	State	Zip Code

Person/Agency/Organization to Receive Information:

<<TCSE Caseworker Name>>	Eastern Shoshone Tribe Child Support Program
<<TCSE Caseworker Title>>	
Name of party information is to go to	Name of Organization

PO Box 1573 Fort Washakie, WY 82514

Address: Street	City	State	Zip Code
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Specific Information Authorized for Release:

Note: Internal Revenue Service regulations prohibit release of any IRS data to any people other than to the involved parties. If the information in the question was initially from the IRS, it cannot be provided.

Purpose or Need for Release of Information:

Date: _____

I understand that I may revoke this authorization, in writing, at any time except where information has already been released as a result of this authorization. Unless revoked, this authorization remains in effect until the expiration time I have indicated and initialed below:

_____ Authorization expires as of _____. (Date)
_____ Authorization expires _____ months from the date I sign this authorization.
_____ Authorization expires after the following action takes place:

I understand that if I am protected by a restraining order or I have reason to believe I may be emotionally or physically harmed, I have a right to request that information on my whereabouts be withheld from anyone including other parties to my Court case. I hereby release the Eastern Shoshone Tribe and the Easatern Shoshone Tribe Child Support Program and its designee named above from liability for the release of any information authorized under this agreement.

As evidenced by my signature below, I hereby authorize disclosure of records to the person(s) or agency(s) specified above.

Signature of Individual Who is Subject of Record

Date Signed

Signature of Person Legally Authorized to Consent to Disclosure

Date Signed

Relationship to Individual Who is Subject of Record

Signature of Witness

Title

Date Signed

-OR-

Subscribed and sworn to before me on this _____ day of _____, _____.

Notary/Court Clerk

My commission expires: _____